STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155764	B. WING		02/29/2012	
		1		ET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		N 87TH AVE		
SPRING	MILL HEALTH CAI	MPUS	MERRILLVILLE, IN 46410			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0000						
F0000	This visit was for Complaint IN00 Complaint IN00 Federal/State de allegations are c	or the Investigation of 104470.  104470- Substantiated, ficiencies related to the ited at F225 and F226.  Sbruary 27, 28, and 29,  10739 155764 N/A  N, TC RN RN RN  S:	F0000		n th the tree ions ices this in to to to its the toring an ence	
	Other: 75					
	Total: 115	,				
	Sample: 3					
	Residential sam	nle: 2				
	1 Condential Sain	ριο. 2				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

CKGV11

Facility ID:

TITLE

PRINTED: 03/19/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:  155764	A. BUILDING B. WING	00	COMPLETED 02/29/2012			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  101 W 87TH AVE  MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	cited in accordan	es reflect state findings ace with 410 IAC 16.2. completed on March 1, alkner, RN						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CKGV11

Facility ID: 010739

If continuation sheet Page 2 of 15

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		155764	B. WIN	G		02/29/	2012
	ROVIDER OR SUPPLIER			101 W 8	ADDRESS, CITY, STATE, ZIP CODE 37TH AVE LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDENCE NAME OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	i	DATE
F0225 SS=D	483.13(c)(1)(ii)-(INVESTIGATE/F ALLEGATIONS/ The facility must have been found neglecting, or mi of law; or have h State nurse aide neglect, mistreat misappropriation any knowledge it law against an eindicate unfitnes or other facility s registry or licens  The facility must violations involvi abuse, including and misappropriareported immediate facility and to with State law the procedures (inclucertification ager  The facility must alleged violations and must preven while the investignated represented to the adesignated represented in accord (including to the agency) within 5 and if the alleged	iii), (c)(2) - (4) REPORT INDIVIDUALS not employ individuals who I guilty of abusing, estreating residents by a court ad a finding entered into the registry concerning abuse, ment of residents or of their property; and report t has of actions by a court of mployee, which would s for service as a nurse aide taff to the State nurse aide ing authorities.  ensure that all alleged ng mistreatment, neglect, or injuries of unknown source ation of resident property are ately to the administrator of to other officials in accordance rough established uding to the State survey and		IAG	JEPICIENCI)		DATE
	Based on record	review and interview, the	F02	25	Further investigation was completed at the time of the survey. No negative outcomes		03/23/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CKGV11

Facility ID: 010739

If continuation sheet

Page 3 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		155764	B. WIN			02/29/2012	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	<u>t</u>		101 W 8	87TH AVE		
	MILL HEALTH CAN				LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	were noted.2. All residents are	DATE	
	1	thoroughly investigate			risk for the alleged deficiency.	e al	
	_	egation of abuse to the			Investigations for incidents wil	l be	
		partment of Health			reviewed for thoroughness and		
	l ` ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′ ′	and failed to ensure			appropriate notification to ISD	PH (	
	residents' were p	rotected after an			Indiana State Department of		
	allegation of abu	allegation of abuse was voiced, for 1 of 3			Health) by the DHS/designee	·	
	residents review	ed for abuse in a total			Additional investigating or reporting will be completed.		
	sample of 3. (Re	esident #D)			accordingly . 3. DHS or design	nee	
					will in-service nurses on		
	Findings include	:			investigation procedures on		
					facility policy and state reporta	ible	
	Resident #D's record was reviewed on				guidelines. Nurses will be required to notify the Executive		
		a.m. The resident's			Director or designee of situation		
		ed, but were not limited			requiring an incident report .4.		
	~				DHS or designee will review		
	to, dementia and	anxiety.			investigations within 24 hours of		
					the incident and report to ISDI	1	
		been admitted to the			accordingly. Trends will be brought to monthly QA X 6		
		on 02/17/12 at 12:20 p.m.			months or until 100% complian	nce	
		ated the resident had			is achieved.Compliance date :		
		acy Unit (Alzheimer's			03/23/12		
	Unit) at the facil	ity prior to this					
	admission.						
	The resident's be	havior report, dated					
	02/21/12 through	n 02/28/12, indicated the					
	resident exhibite	d no behaviors.					
	The resident's ad	mission assessment,					
	dated 02/17/12 and untimed, indicated the						
	resident's speech was understood and the						
	resident understood communications. The						
	assessment indicated the resident had short and long term memory problems,						
	1						
	and required one	assistant for activities of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CKGV11

Facility ID: 010739

If continuation sheet

Page 4 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	CONSTRUCTION  00	ľ í	TE SURVEY MPLETED	
		155764	A. BUILDING B. WING		<del></del> 02/	29/2012
	PROVIDER OR SUPPLIER		STREET 101 W	ADDRESS, CITY, STATE, ZIP 87TH AVE BILLVILLE, IN 46410	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	daily living.					3.112
	p.m., indicated, 'of Nursing) (Dol (Assistant Direct Resident c/o (con name) (Male CN #1 name) was not c/ (with) Resider room c/ him, (CN that (CNA #1 nat touch resident is room, Inform (C back in room & care of Resident. evening shift for of resident."  A Nurses' Note, indicated, "Spok (Power of Attorry prefers for female	dated 02/17/12 at 2:30 Unformed DON (Director N's name) and ADoN or of Nursing name) that implained of) (CNA #1 A) of being fresh, (CNA at in the room by himself at, (CNA #2 name) was in NA #2 name) state [sic] ime) did not say any &/or [sic] was just in the NA #1 name) not to go to have a female to take I pass on it to (sic) female only to take care  dated 02/17/12 at 3 p.m., is c/resident et POA it in the POA it in t				
	entered her room does not want me	hat above named CNA net introduced self & she en/boys care for her. Info s written by the DoN)				
	indicate a thorou completed, an as had been comple physician being	of documentation to gh investigation had been sessment of the resident ted, the resident's notified,the id been notified, and the				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CKGV11

Facility ID: 010739

If continuation sheet

Page 5 of 15

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155764			ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/29/2012
	PROVIDER OR SUPPLIE		101 W	ADDRESS, CITY, STATE, ZIP CODE 87TH AVE LLVILLE, IN 46410	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	1	fied after the resident lle CNA had been "fresh"			
	a.m., the DoN in the resident and the male CNA he resident. She in investigate or reindicated she has resident about we CNA being "freshad said CNA # anything to the number of the During an interval.m., the DoN in notified the Adnindicated she was notified him. She think it was an awas another CN told CNA #1 had During an interval.m., the Admin not remember the to him. He indicated about it, to	riew on 02/29/12 at 9:57 adicated she thought she ministrator, but was not otified him that day. She as unsure when she he indicated she didn't lllegation because there A in the room and was d not touched the resident.  riew on 02/29/12 at 10:08 istrator indicated he did he incident being reported cated the first time he had to the best of his s 02/28/12. (This was 7			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CKGV11

Facility ID: 010739

If continuation sheet

Page 6 of 15

PRINTED: 03/19/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155764			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPI	ETED	
		155764	B. WIN	G		02/29	/2012
NAME OF F	PROVIDER OR SUPPLIER	4			ADDRESS, CITY, STATE, ZIP CODE		
SPRING	MILL HEALTH CAN	MPUS			LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY		DATE
	_	iew on 02/28/12 at 11:30					
		arse on duty at the time of					
		dicated she was doing an e resident when the					
		CNA #1 had been					
		She indicated she had					
	asked the resident what she meant by being fresh, and the resident did not						
	answer her question. LPN #3 then						
	indicated she had left the room and then returned to the room about 15 minutes						
	later and Resident #D again told her CNA #1 had been fresh with her. LPN #3						
		1 had not been back in					
		om. LPN #3 indicated					
		it made the allegation the					
		then went and talked to					
	CNA #1 and CN						
		1 the chart about the					
		A #1 was completed only					
	_	had repeated the					
		15 minutes after the first					
		#1 indicated since the					
		eated the allegation again,					
	_	DoN and the ADoN and					
		better document the					
		#3 indicated she had not					
	1	stay out of the resident's					
		esident repeated the					
		ndicated CNA #1 had					
	1	ds with other residents.					
	_	d a Circumstance Form					
		ed out. She indicated she					
		the resident's physician					
							<u> </u>

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CKGV11

Facility ID: 010739

If continuation sheet

Page 7 of 15

PRINTED: 03/19/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155764	A. BUILDING  B. WING	00 	COMPLETED 02/29/2012			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  101 W 87TH AVE  MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	about the allegati							
	This Federal tag IN00104470.	relates to Complaint						
	3.1-28(d)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CKGV11

Facility ID: 010739

If continuation sheet Page 8 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING OO COMPLETED			ETED	
		155764	B. WIN			02/29/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				B7TH AVE		
SPRING	MILL HEALTH CAN	/IPUS			LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	, i	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
F0226	483.13(c)						
SS=D	DEVELOP/IMPL ETC POLICIES	MENT ABUSE/NEGLECT, develop and implement					
		nd procedures that prohibit					
	residents and mi	glect, and abuse of sappropriation of resident					
	property.		F02	26	Further investigation was		03/23/2012
	D 1	no to condition to a	1.02	20	completed at the time of the		03/23/2012
		review and interview, the			survey. No negative outcomes	i	
	*	follow their policy for			were noted.2. All residents are		
	abuse, related to				risk for the alleged deficiency.		
		e facility Administrator,			Investigations for incidents will		
	the Indiana State	Department of Health			reviewed for thoroughness and appropriate notification to ISD		
	(ISDH), and the	residents' physician, the			Indiana State Department of	11(	
	facility also faile	d to completed a			Health) by the DHS/designee.		
	thorough investig	gation and protect the			Additional investigating or		
	residents after an	allegation of abuse for 1			reporting will be completed.		
	of 3 residents rev				accordingly . 3. DHS or design	iee	
	allegations in a to				will in-service nurses on investigation procedures on		
	(Resident #D)	o <b>u.</b>			facility policy and state reporta guidelines. Nurses will be	ble	
	Findings include	:			required to notify the Executive Director or designee of situation requiring an incident report .4.		
	Resident #D's red	cord was reviewed on			DHS or designee will review		
		a.m. The resident's			investigations within 24 hours	of	
		ed, but were not limited			the incident and report to ISDF		
	_				accordingly. Trends will be		
	to, dementia and	anxiety.			brought to monthly QA X 6 months or until 100% compliar	nce	
	The resident had	been admitted to the			is achieved.Compliance date :		
		on 02/17/12 at 12:20 p.m.			03/23/12		
		ated the resident had					
	_	acy Unit (Alzheimer's					
	Unit) at the facili	ity prior to this					
	admission.						
	l		1				I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CKGV11

Facility ID: 010739

If continuation sheet

Page 9 of 15

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	(X2) MU A. BUILI B. WING	DING	NSTRUCTION  00	(X3) DATE COMPL 02/29/	ETED
	PROVIDER OR SUPPLIER			STREET A 101 W 8	DDRESS, CITY, STATE, ZIP CODE 17TH AVE LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
		havior report, dated 102/28/12, indicated the d no behaviors.					
	dated 02/17/12 a resident's speech resident understo assessment indic short and long te	mission assessment, and untimed, indicated the was understood and the rod communications. The ated the resident had arm memory problems, assistant for activities of					
	p.m., indicated, 'of Nursing) (Dol (Assistant Direct Resident c/o (corname) (Male CN #1 name) was not c/ (with) Resider room c/ him, (CN that (CNA #1 natouch resident is room, Inform (C) back in room & to care of Resident.	Informed DON (Director N's name) and ADoN or of Nursing name) that implained of) (CNA #1 A) of being fresh, (CNA t in the room by himself at, (CNA #2 name) was in NA #2 name) state [sic] ime) did not say any &/or [sic] was just in the NA #1 name) not to go so have a female to take I pass on it (sic) to female only to take care					
	indicated, "Spoke	dated 02/17/12 at 3 p.m., e c/ resident et POA ey) (Name), resident					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CKGV11

Facility ID: 010739

If continuation sheet

Page 10 of 15

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155764	B. WIN			02/29/2	2012
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
					B7TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		*		TAG	DEFICIENC!)	<del> </del>	DATE
	prefers for females to care for her.						
	Resident stated that above named CNA						
		n et introduced self & she					
		en/boys care for her. Info					
	noted." (This was written by the DoN)						
	There was a lack of documentation to						
	indicate a thorough investigation had been						
	completed., an assessment of the resident						
	had been completed, the resident's						
	physician being notified, the administrator						
	had been notified, and the ISDH being						
		e resident indicated the					
		been "fresh" with her.					
	mare Cryr nad c	ven nesn with her.					
	   During an interv	iew on 02/28/12 at 9:05					
	_	dicated she spoke with					
		the POA. She indicated					
		ad not touched the					
		dicated she did not					
		port the allegation. She					
	,	d not talked to the					
		hat she meant about the					
		sh" since the other CNA					
		1 had not touched or said					
	anything to the r						
	During an interv	iew on 02/28/12 at 11:30					
	1	urse on duty at the time of					
		ndicated she was doing an					
	1 ,	ne resident when the					
	resident told her CNA #1 had been						
		She indicated she had					
		nt what she meant by					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CKGV11

Facility ID: 010739

If continuation sheet Page 11 of 15

PRINTED: 03/19/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155764	B. WIN			02/29/	2012
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
					B7TH AVE		
	MILL HEALTH CAN			MERRIL	LLVILLE, IN 46410		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
		the resident did not					21112
		ion. LPN #3 then					
	•	l left the room and then					
	returned to the ro	om about 15 minutes					
	later and Residen	at #D again told her CNA					
	#1 had been fresh	n with her. LPN #3					
	indicated CNA #	1 had not been back in					
	the resident's roo	m. LPN #3 indicated					
	when the resident	t made the allegation the					
	second time, she	then went and talked to					
	CNA #1 and CNA	A #2 and her					
		the chart about the					
	allegation of CNA	A #1 was completed only					
	after the resident	had repeated the					
	allegation again,	15 minutes after the first					
	allegation. LPN	#1 indicated since the					
	resident had repe	ated the allegation again,					
	she then told the	DoN and the ADoN and					
		petter document the					
		#3 indicated she had not					
		tay out of the resident's					
		esident repeated the					
	_	ndicated CNA #1 had					
	_	ls with other residents.					
		d a Circumstance Form					
		ed out. She indicated she					
		he resident's physician					
	about the allegati	on.					
	During on intervi	ew on 02/29/12 at 9:57					
	_	dicated she thought she					
		Administrator, but was					
		tified him that day. She					
		s unsure when she					
	marcated site was	, diffure which plic					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CKGV11

Facility ID: 010739

If continuation sheet Page 12 of 15

PRINTED: 03/19/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION  00			(X3) DATE SURVEY  COMPLETED	
155764				LDING		02/29/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					B7TH AVE		
SPRING MILL HEALTH CAMPUS				MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)	DATE	
	notified him. She indicated she didn't						
	think it was an allegation because there was another CNA in the room and was						
	told CNA #1 had not touched the resident.						
	During an interview on 02/29/12 at 10:08						
	a.m., the Administrator indicated he did						
	not remember the	e incident being reported					
	to him. He indic	ated the first time he had					
	heard about it, to						
	•	02/28/12. (This was 7					
	days after it had	occurred.)					
	A facility policy	dated 09/16/11, and					
		e Administrator as					
		ABUSE AND NEGLECT					
		GUIDELINES",					
		staff is required to report					
	concerns, incider	nts and grievances					
	immediately to y	our manager and/or					
	Executive Direct	or and Director of Health					
		DIATELY notify the					
		orThe Executive					
	_	nee must notify the					
	residents(s)' phys	· /					
		le partyComplete an ident Report. Refer to					
		Incident ProgramThe					
		or is responsible for: 1.					
		ne State Department of					
		onUpon identification					
		seimmediately provide					
	-	the residentThis may					
			<u> </u>				1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CKGV11

Facility ID: 010739

If continuation sheet

Page 13 of 15

STATEMENT OF DEFICIENCIES				ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
				LDING	00	COMPLETED	
155764		B. WING			02/29/2012		
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF FROVIDER OR SUFFLIER			101 W 87TH AVE				
SPRING MILL HEALTH CAMPUS			MERRILLVILLE, IN 46410				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION		
TAG				TAG	DEFICIENCY)	DATE	
	includeProviding 1:1						
	monitoringSuspend suspected employee						
	pending outcome of investigationThe						
	Executive Director is accountable for						
	investigating and reportingImmediately						
		n 24 hours complete an					
	initial report to applicable state						
	agencies"						
	An undated, faci	lity policy received from					
	the DoN on 02/2	7/12 at 3:15 p.m., titled,					
	"ACCIDENT AN	ND INCIDENT					
	REPORTING G	UIDELINES", indicated,					
	"To ensure all	accidents, incidents and					
	allegations of ab	use involving					
	residentsare in	vestigated and reported to					
	the facility admir	nistrationAn Accident					
	and Incident For	m shall be completed for					
	knownabuse al	legationsThe assigned					
	nurse or nursing	supervisor shall complete					
	an assessment an	nd provide medical					
	interventions as	warranted. 5. Reporting					
	of incident, accid	lents and abuse to state					
	and federal agen	cies shall be in					
		cordance with agency					
	•	ne assigned nurse or					
		or shall: 1. Examine all					
		t or abused victims. b.					
	· /	ing physician or medical					
	director of the oc						
		ion shall be initiated by					
	1	rse and/or nursing					
		mpleting the appropriate					
		nd Reassessment form'					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CKGV11

Facility ID: 010739

If continuation sheet Page 14 of 15

PRINTED: 03/19/2012 FORM APPROVED OMB NO. 0938-0391

	DF CORRECTION IDENTIFICATION NUMBER:  155764	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMPI 02/29	ETED		
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE  101 W 87TH AVE  MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	and forwarded to the Director of Health Services"						
	This Federal tag relates to Complaint IN00104470.						
	3.1-28(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CKGV11

Facility ID: 010739

If continuation sheet

Page 15 of 15